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cardioversion

**cardioversion**

cardioverter

carditis

care, adult day

care, cluster

cardioversion (k|'df-M-v&r''zhTn) [" + L. *versio*, a turning] The restoration of normal sinus rhythm by chemical or electrical means.

When performed medicinally, the procedure relies on the oral or intravenous administration of antiarrhythmic drugs. Electrical cardioversion relies instead on the delivery of synchronized shock of direct electrical current across the chest wall. It is used to terminate arrhythmias such as atrial fibrillation, atrial flutter, supraventricular tachycardia, and well-tolerated ventricular tachycardia. Unlike defibrillation, which is an unsynchronized shock applied during dire emergencies, electrical cardioversion is timed to avoid the T wave of cardiac repolarization to avoid triggering malignant arrhythmias. A patient will almost always require sedation and analgesia before the procedure.

CAUTION: Electrical cardioversion should not be used in patients who have recently eaten (because of the risk of regurgitation of stomach contents), in patients with severe electrolyte abnormalities, in patients with some drug overdoses, or in patients unable or unwilling to give informed consent. Patients need to be advised of the risks of cardioversion, including the rare precipitation of ventricular fibrillation and ventricular tachycardia, the development of bradyarrhythmias or heart blocks, and the possibility of embolic stroke.

PATIENT CARE: The procedure, expected sensations, complications, and risks are explained to and clarified for the patient. Emotional support is provided throughout the procedure and at its conclusion. The patient's medication history is reviewed, and cardiac glycoside use is reported to the health care provider, along with the patient's electrolyte levels. Emergency equipment (including ACLS drugs, a bag-valve-mask resuscitator, supplemental oxygen, suction, laryngoscope and appropriate size ET tube, defibrillator, and supplies for intravenous injection) are assembled at the bedside. In the hospital setting, emergency personnel (respiratory technicians, anesthesiologists, nurses, and paramedics) may assist the attending physician. The patient's vital signs are checked, an intravenous infusion is started, and the patient is connected to a continuous ECG monitor. Dentures are removed from the mouth, and necklaces or pendants, as well as nitroglycerin patches, are removed from the chest and neck. Chest electrodes are placed to facilitate recording of tall R waves without interfering with paddle placement. A 12-lead ECG is obtained and the patient is given enriched oxygen to breathe. The patient is placed in a supine position, and adequate

EXHIBIT

tabbles*

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fibrillation

**fibrillation**

fibrillin

fibrillogenesis

fibrin

fibrin glue

Letter F[fiber – finger cot](#)[fibrillation](#)

- [atrial fibrillation](#)
- [lone atrial fibrillation](#)
- [paroxysmal atrial fibrillation](#)
- [ventricular fibrillation](#)

defibrillation 1. Termination of ventricular fibrillation (vfib) with electrical countershock(s).

This is the single most important intervention a rescuer can take in patients who have suffered cardiac arrest due to vfib or pulseless ventricular tachycardia. 2. A term formerly used to signify termination of atrial fibrillation.

The contemporary terms are conversion or cardioversion.

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fibrillation



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fibrillation (fK"brWl-~'shTn) 1. Formation of fibrils. 2. Quivering or spontaneous contraction of individual muscle fibers. 3. An abnormal bioelectric potential occurring in neuropathies and myopathies.

atrial fibrillation ABBR: AF. The most common cardiac arrhythmia, affecting as many as 10% of people age 70 and over.

It is marked by rapid, irregular electrical activity in the atria, resulting in ineffective ejection of blood into the ventricles. Blood that eddies in the atria may occasionally form clots that may embolize (esp. to the brain, but also to other organs). As a result AF is an important risk factor for stroke. It may also contribute to other diseases and conditions, including congestive heart failure, dyspnea on exertion, and syncope.

ETIOLOGY: AF may occur in otherwise healthy persons with no structural heart disease ("lone" AF) (e.g., during stress or exercise). It may also develop acutely during alcohol withdrawal; in patients with underlying arrhythmias (such as tachybrady syndrome or Wolff-Parkinson-White syndrome); after cardiac surgery; during cocaine intoxication; in hypertensive urgencies, hypoxia, or hypercarbia (carbon dioxide retention); during myocardial infarction; in pericarditis and pulmonary embolism; or as a consequence of thyrotoxicosis or other metabolic disorders. Chronic AF usually occurs in patients with structural abnormalities of the heart, such as cardiomyopathies; enlargement of the left atrium; mitral valve disease; or rheumatic heart disease.

SYMPTOMS: Some patients may not notice rapid or irregular beating of their heart, even though the ventricular rate rises to 200 bpm. Most patients, however, report some of the following symptoms at slower heart rates (100 bpm or greater): dizziness, dyspnea, palpitations, presyncope, or syncope.

DIAGNOSIS: Patients who present with their first episode of atrial fibrillation are typically evaluated with thyroid function tests, cardiac enzymes, a complete blood count, and blood chemistries. In patients with a cardiac murmur or evidence of congestive heart failure, echocardiography is typically performed.

TREATMENT: The acutely ill patient with a rapid ventricular response and signs or symptoms of angina pectoris, congestive heart failure, hypotension, or hypoxia should be prepared for immediate cardioversion. Patients who tolerate the rhythm disturbance without these signs or symptoms are typically treated first with drugs to slow the heart rhythm (e.g., calcium-channel blockers, beta blockers, or digoxin). Anticoagulation (e.g., with warfarin) markedly reduces the risk of stroke and